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ABSTRACT

Reported are results of a survey (1972) to determine trends in residential services for the mentally retarded, with particular focus on residential facilities, community involvement, and placement procedures. Respondents (62% of 211 questionnaires sent) represent public residential care facilities in the United States and Canada, or are state coordinators, members of the President's Committee on Mental Retardation, or specialists. Twenty-two questions request such information as categories of present residential population, percentage of residents employed for renumeration, or waiting list according to categories. Key findings indicate trends such as the following; that possibly one half of all institutionalized could be returned to appropriately programed community living facilities, that residential facility personnel have expertise and knowledge, that attention be given to respite and short-term care programs and to community programs in which institutional residents participate, that parental participation be planned at time of admitting a child, that institutional staff do not cooperate sufficiently with community agencies to train community program coordinators, and that universities should be more involved with residential facilities and intervention programs. (MC)

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# Report

OF

# TRENDS

IN

## RESIDENTIAL SERVICES for the MENTALLY RETARDED

1972

EC 052 155

NATIONAL ASSOCIATION OF SUPERINTENDENTS OF PUBLIC RESIDENTIAL FACILITIES

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# TRENDS: Residential Services for the Mentally Retarded*

By: David Rosen, M.S., and Laurence B. Callan, Ph.D.

## FOCUS: Community -- Facility Interaction

Trends in Residential Services for the Retarded were first investigated nationally and reported on in 1971. That investigation sought to determine empirically what was occurring in public and private residential care facilities regarding programs and services for the mentally retarded throughout the United States. This study was reported and published June 11, 1971. It was supported in part by a research grant from the President's Committee on Mental Retardation (PCMR). The substance of the inquiry was derived from the PCMR's Residential Services for the Mentally Retarded: An Action Policy (1970). Much valuable information was retrieved in this way. A reference point for future studies was established which also permits comparisons to be made between present and past programs. The study discussion report specifies many of the strengths in program areas and indicates areas for needed improvements.

One study area cited as offering the greatest optimism and encouragement was that related to increased interaction taking place between residential facilities and "community agencies". It was noted that this interface would hopefully serve as an impetus for improved, relevant services.

In the past year, since the report was issued, there has been greater emphasis and focus in many states for interaction between residential facilities and community agencies to achieve broader involvement in the return of many retarded residents to community living. In fact, this direction has been mandated in most states by improved operational approaches in the various disciplines involved in administration of treatment, training, and therapy. Another important force for increasing such interaction, although not documented at the present time, is the result of litigation relative to the rights of retarded citizens by the courts in several states across the nation.

## PURPOSE

The purpose of the 1972 survey was to: (1) collect similar data on selected issues reported on in the original survey report; (2) compare and analyze this data to determine if a change occurred; if so, in what direction; if not, what conclusions may be derived from the non-change status; (3) seek new information, particularly focusing on residential facilities and community involvement and placement procedures utilized in various sectors of the country (analysis of this data might lead to the identification of models adaptable to local conditions for replication and implementation, as well as identifying models that had negative or limited success); and (4) to disseminate the findings of this survey inquiry to widely selected target populations, including decision makers at national and state levels, providers of care, and consumers of such services, as well as to the general public and major professional groups committed to efforts for improvement and enhancement of life styles of this portion of our population.

*Supported in part by research grant from the President's Committee on Mental Retardation.

In this report, item number 3 has been emphasized: to seek new information, particularly focusing on residential facilities and community involvement and placement procedures utilized by residential facilities in various sectors of the country.

## SCOPE

The 1972 Survey of Trends was initiated in January of this year. A preliminary questionnaire was designed and pre-tested with selected superintendents, a state coordinator of mental retardation services, and expert mental retardation personnel working at the national level. The pre-test group was asked to respond to the draft questionnaire in terms of accuracy, clarity, and pertinence of questions, and to make recommendations for change. As many of these recommendations as possible were used in developing the final format.

## NATURE OF SAMPLE

The study population included all public residential care facilities in the United States. Copies of the questionnaire were also mailed to all state coordinators, selected members of the PCMR, and those specialist personnel involved in the pre-test. The population mailed copies of the questionnaire and expected to respond included 202 Unites States superintendents and nine (9) superintendents of Canadian residential care facilities.

## DATA COLLECTION

The self-administered questionnaire was constructed in such a manner as to permit easy return mailing to the Institute for the Study of Mental Retardation and Related Disabilities, the University of Michigan. The completed questionnaires were coded and processed for direct key-punching by contract staff at the Institute for Social Research, University of Michigan. Cut-off date for questionnaires was May 8, 1972. Tabulations were prepared, using a means and marginals computer program; and initial analysis was completed on May 10, 1972. A total of 147 superintendents responded. This represented a total response of seventy per cent (70%) from both the United States and Canada. A number of questionnaires were incomplete or came in late and were not included in the tabulations. This report only includes data compiled from sixty-two per cent (62%) of the total 211 possible respondents.

Careful attention is required in interpreting data in the following tables and narrative. Many replies are estimates or opinions as opposed to actual hard data; much of the data asked for were not reasonably available to all respondents. A further word: data reported is in per cent, not in number; that is, the figures reported here are percentages of respondents' estimates or opinions and may not represent actual numbers of programs, institutions, facilities, or other content.

QUESTION 1: What is the present population in your facility(s) as to category?

TABLE A: 1972 Population in Residential Facilities

| Classification | Per Cent |
|---|---|
| Mild | 15 |
| Moderate | 22 |
| Severe | 29 |
| Profound | 34 |

Sixty-three per cent (63%) of institutionalized retardates were classified as being in severe or profound categories, an increase over previous statistical studies. This increase is undoubtedly due to a number of factors: (1) the application of current philosophy and programmatic emphasis in residential facilities are succeeding in preparing individuals in mild and moderate categories for community living; (2) community agencies (for example, the educational system and vocational rehabilitation services) are developing programs for mildly and moderately retarded citizens which eliminate the need for institutionalizing persons in these categories; and (3) many state residential facilities are admitting only individuals who are classified as severe and profound. It might be hypothesized that as institutions successfully develop more skills and work more intensely with community agencies that consequently these agencies will develop similar programs in the community, thereby again reducing the need for institutional placements for many in all categories of retarded persons.

QUESTION 2: What per cent of your residents, in community placements, within the past year performed some type of remunerative work in the community?

TABLE B: Residents in Community Placements Performing Remunerative Work

| Age | Mean % | Wage Range | Months on the Job |
|---|---|---|---|
| 16 to 20 | 14 | 64¢ to $2.27 | 6 |
| Over 20 | 24 | 84¢ to $2.65 | 12 |

The summation of the data suggests that thirty-eight per cent (38%) of individuals on community placements are performing remunerative work. The reported average wage range for sixteen (16) to twenty (20) year old retarded persons was sixty-four cents (64¢) to $2.27 per hour; and these individuals, making up to fourteen per cent (14%) of the total cited above, have been on their jobs for an average of six (6) months. It was further reported that residents over twenty (20) years of age, twenty-four per cent (24%) of the total, are receiving a slightly higher wage range, eighty-four cents (84¢) to $2.65 per hour. These individuals have been employed on an average of twelve (12) months.

QUESTION 3: What per cent of your residents do you estimate have been or will be employed for remuneration?

TABLE C: Estimates on Employment for Remuneration

| Age | % Past 2 Years | % Next Year | % 1977 |
|---|---|---|---|
| 16 to 20 | 8 | 9 | 12 |
| Over 20 | 13 | 12 | 14 |
| Employed 12 months or longer | 16 | 16 | 17 |

Respondents were asked to estimate remunerative employment potential for the next year and five years hence of their residents in the sixteen (16) to twenty (20) year age categories. The data indicates a flattening out or straight line increase as opposed to a more promising uphill curve. It is probabl that there is a changing population in institutions to higher numbers of severe and profound residents, thereby reducing the probabl number of people capable of remunerative employment. It is also conceivable that some institutions may be underestimateing the potential capability of their residents.

QUESTION 4: What per cent of the retarded population in your geographic service area (catchment area) would you estimate will need residential care services from your facility next year?

TABLE D: Estimated Need for Residential Care Services in 1973

| Type of Care | Per Cent |
|---|---|
| Respite (1 to 6 weeks) | 4 |
| Short-term residential services (less than 1 year) | 5 |
| Medium-term residential services (from 1 to 3 years) | 9 |
| Long-term residential services (more than 3 years) | 16 |

Respondents were asked to estimate the need for different residential care services in 1973. The four (4) models listed for choice were: (1) respite care, one to six weeks; (2) short-term residential services, less than one year; (3) medium-term residential services, from one to three years; and (4) long-term residential services, more than three years.

A much higher, comparative per cent of the respondents' estimated need for long-term residential services and medium services than for respite care or short-term residential care services under one year. This may be due to a number of the following reasons or other equally significant reasons: (1) insufficient numbers of community facilities and programs, especially for the severe and profound, exist at the present time; (2) some administrative personnel have not as yet adopted the philosophy of community placement for severely and profoundly retarded individuals; (3) other operations constraints

which suggest low priority and, consequently, time devoted to developing respite and short-term services; (4) financial accounting procedures involved in respite care services may be viewed as tedious and confusing; and (5) respite care may also tend to tie up bed space and require increased evaluation time, parent counseling, as well as the development of additional procedures relative to personal property needs of the individual.

QUESTION 5: Has your institution population been decreased by community placement over the last five years? If yes, please indicate where these former residents have been placed.

TABLE E: Institution Population Decrease Due to Community Placement

| Place | Per Cent |
|---|---|
| Own (parental or guardian home) | 18 |
| Other family home | 7 |
| Foster home | 8 |
| Group home | 11 |
| Nursing home | 14 |
| Intensive (nursing) care facility | 5 |

The majority of respondents, seventy-two per cent (72%), indicated that their institutional population had decreased due to community placement activities over the past five (5) years. Nursing homes, group homes, and foster homes are the major placement facilities for former residents. The respondents indicated that the majority of individuals were (1) returned to their own parental or guardian home, (2) placed in nursing or intensive care facilities, (3) placed in group homes, or (4) placed in foster homes.

QUESTION 6: Do you have a waiting list of retarded individuals approved for admission to your facility? If yes, please indicate how many by category and how many could be placed in community facilities if community facilities were available.

TABLE F: Waiting List for Admission

| Approved for Facility | Could be Placed in Community Facility (Per Cent by Category) |
|---|---|
| 10 mild | 12 mild |
| 15 moderate | 18 moderate |
| 20 severe | 16 severe |
| 20 profound | 9 profound |
| 8 infirm | 5 infirm |

More than half the respondents, fifty-four per cent (54%), stated they had a waiting list of individuals approved for admission. When one looks at the per cent by categories of individuals approved for facilities and those that could be placed in community facilities, it becomes apparent that residential facility staff are of the opinion that the more severe and

profound require institutional placement or that there are few appropriate community facilities available for individuals in profound, severe, or infirm categories.

QUESTION 7: Approximately what per cent of your residents participate in the following community programs or activities in the community?

TABLE G: Residents Participating in Community Programs or Activities

| Community Programs | Per Cent | Increase Over Last Year | Average Staff Man Hours Per Week |
|---|---|---|---|
| Recreation | 34 | 7 | 81 |
| Social | 30 | 3 | 64 |
| Educational | 10 | 7 | 39 |
| Occupational | 7 | 5 | 44 |
| Religious | 11 | 2 | 7 |
| Volunteers | 14 | 5 | 15 |

Table G indicates some encouraging trends for greater involvement in community-based programs. Increases are noted on the per cent of residents participating in community programs or activities. There is a greater proportion of staff man hours devoted to recreation and social programs when compared with occupational and educational program involvement. This may be due to the fact that historically recreation and social community programs or activities served as the first entre of residents into the community. As a result of this data, the question may be asked whether there are adequate educational and training services in proximity to the institutions; although institution administrators may have accepted the use of community services for recreation and social activities, the responses indicated they may still be of the opinion that all other requirements of the retarded are best met at the institution. Conjecture on this reporting raises question as to the number and kind of programs (day care, work activities, others) that are available.

QUESTION 8: Have any of the following community or regional facilities existed or been started (opened in your geographic service area -- catchment area)?

TABLE H: Community/Regional Facilities

| Community Facilities | % Yes | Existed Pre 1971 (mean) | Opened 1971-72 |
|---|---|---|---|
| Regional centers | 54 | 1.0 | 1 |
| Regional residential centers | 48 | 0.1 | 0 |
| Day care centers | 82 | 6.0 | 4 |
| Nursing homes | 76 | 12.0 | 7 |
| Boarding homes | 65 | 8.0 | 7 |
| Vocational/occupational centers | 82 | 3.6 | 2 |
| Group homes/hostels | 71 | 3.0 | 1 |
| Social/recreational centers | 55 | 1.0 | 2 |
| Treatment/training centers | 63 | 3.0 | 2 |
| Elementary secondary education classes for exceptional children | 90 | 17.0 | 11 |
| Home consultation by staff | 67 | 5.0 | 7 |

This table might be misleading to the casual reader. The high figures mean that individual respondents indicated that these various community facilities existed in their catchment areas, but one does not see sufficient development of additional facilities in order to have available appropriate alternatives for placement of retarded individuals. Service programs to correlate with community programs must also be increased to a much larger degree than what is available today. Largest increases are seen in nursing and boarding homes and vocational and occupational centers for the retarded. This trend is indeed encouraging; but as noted above, greater emphasis, especially in group homes and hostels, at a highly accelerated rate is critical. The above table identified community regional facilities operating in catchment areas congruent to responding residential care institutions. Few existed before 1971, and very few were opened last year. There is wide range in the number of such facilities operating in these catchment areas, but the growth in numbers of these facilities is minimal. Some positive trends are noted in that special education classes seem to be on the increase as is some consultation provided by residential facility staff. There are nine (9) other categories of community-based facilities indicated here that do not show an increase in number. It is important to note that twenty per cent (20%) of the respondents have not assigned staff personnel to be responsible for community placement programs.

QUESTION 9: Please check the appropriate yes or no column regarding your facility's programs for community placement activities and indicate staff man-hours per week involved in the programs.

TABLE I: Community Placement Activities

| Training of: | Average Number of Staff Hours Per Week |
|---|---|
| Private Home Operators | 4 |
| Foster Home Operators | 4 |
| Group Home Operators | 3 |
| Nursing Home Operators | 4 |
| Potential Employers | 5 |
| Other Training | 2 |

This question elicited a high positive response, indicating the amount of staff work involved in community relations and placement programs. Indications of hours expended in community placement activities require careful examination. This data suggests that twenty-two (22) staff hours a week are devoted to community placement activities. On close examination, this time allocation is diffused among the number of activities indicated above; and diverse programming in community operations is not reflective of active community interaction or effectiveness with this disparate finding. For effective program to occur and to ensure continuing positive results, it would appear that much more time could be allocated to personnel of specific programs, and particularly emphasize activity with potential employers.

Institutional staff have a great deal of expertise which needs to be shared with community program individuals. Other shared activities within the community are encouraging; but a great deal more time can be placed in

each of the following arenas: community, public education, and out-reach programs. This observation is reflected in the next table, indicating community personnel involved with residential care facility staff working on community placement.

QUESTION 10: Please identify community agencies or personnel with whom you or your staff work for community placements.

TABLE J: Community Agencies/Personnel with Whom Staff Works for Community Placement

| Agencies/Personnel | Average Staff Man Hours Per Week |
|---|---|
| Day Care Centers | 7 |
| Foster Homes | 15 |
| Apartment House Owners | 1 |
| Parents | 28 |
| Employers | 15 |
| Special Education Classes | 5 |
| Community Service Groups | 12 |

QUESTION 10A: Does your institution operate "quarter-way" house (on grounds) and/or "half-way" houses (off grounds)?

"Quarter-Way" Houses

Twenty-six per cent (26%) of the respondents indicated that they were operating quarter-way houses on institutional grounds. The range in number of reported homes was one (1) to six (6), with a mean or average number of one (1). The concept of operating quarter-way houses is not new. In most programs, this has been successful in the transition process for retarded individuals going from institutional to community living.

"Half-Way" Houses

Twenty per cent (20%) reported that they operate half-way houses off institutional grounds. The number of houses operated by these facilities ranged from one (1) to seven (7), with an average of three (3).

Strongly linked programs (institution and community) are essential for the acquisition of progressive learning skills for eventual, independent living. Given that there are diverse philosophical views relating to operating half-way or quarter-way houses, this intervention still seems to be a valuable linkage in the appropriate movement toward the goal of community placement of these citizens. It is important to look at the architecture of such buildings used for half-way and quarter-way houses. Much attention should be placed on their resembling as closely as possible the variety of homes with different equipment (such as plumbing fixtures, appliances of various manufacture) that the resident will encounter in his final community placement. In other words, uniformity of such common housing fixtures in the half-way and quarter-way houses will tend to defeat the reality that residents will face in eventual community placements.

QUESTION 12: Do parents participate with residential personnel in community placement reviews and in what capacity and at what specific time intervals; upon notification of the intention of community placement, what per cent of the parents or guardians voice objections; following interaction/counseling follow-up with parents or guardians with institute staff, what per cent continue to object; and in those cases where continued parent/guardian objections exist and where your staff judgement maintains the resident should be placed in the community, what do you do?

TABLE K: Parental Participation in Community Placement Reviews

| In What Capacity | Per Cent | How Often Are They Involved | Per Cent |
|---|---|---|---|
| *Member review team | 43 | Regular basis | 31 |
| *Out-reach worker | 22 | Three months before | 18 |
| Community housing placement | 32 | Time of placement | 57 |
| Public education | 20 | After placement | 35 |
| | | Other | 22 |

*Less than fifty per cent (50%) responded

This table relates to parental participation and community placement. Respondents indicated that parents participate with staff in community placement in fifty-three per cent (53%) of such occurrences. Less than fifteen per cent (15%) of the respondents replied to that question regarding in what capacity parents participated in this activity as a member of the review team or as an out-reach worker. The majority of respondents indicated that this involvement actually occurred only at the time of placement, which suggests a token recognition of parental involvement. The minimal response to this question signifies that this is not performed in the majority of facilities. It further suggests that institutions re-evaluate their placement procedures as appropriate community placement programs can only be developed when retarded persons are evaluated programmatically and re-evaluated on a regular or periodic basis. Meaningful parental involvement, initiated at the point of admission, should be continuous throughout the process leading to eventual community placement goal. This is a basic, philosophical, and pragmatic component of programming. Its absence is a gross deficiency in any programming effort.

On the question relating to parental objection to community placement of their children or adults when notified of such intent by residential care facility personnel, the over-all average shows seventeen per cent (17%) of parents object to such placement. This figure could be larger if residents were considered for placement who are presently passed over for community placement because their parents are perceived to be those who would object to such placement or who had been promised at the time of admission that "their child would be taken care of for life." An observation gained informally from professionals of the study population indicated that the lower average per cent may be due to the fact that many parents are not available

to object to placement procedures. This may be due to the physical absence of some parents (deceased) or to their current age, the age of the resident in question, or where it appears that the resident has been abandoned. There is wide variation of response from all institutions to this question: some indicated no parental objection; while others indicated ninety per cent (90%) of the parents objected. Where counseling or other follow-up involvement with parents who initially objected is offered, the over-all average drops from seventeen per cent (17%) to nine per cent (9%) continuing to object to community placement. Once more, the variation in institutional experience is quite wide, with up to seventy per cent (70%) of parents continuing to object to the intention of community placement. This finding suggests that meaningful parental involvement was not initiated at the point of admission and has not been continuous throughout the process; and in fact, it might be that the parents were involved only at the time of placement or after the fact. Further, when parental objections are sustained, forty-seven per cent (47%) of the respondents indicated that they still place the child or adult in the community, while fifty-three per cent (53%) retain the individual in the institution.

QUESTION 13: Are return options available to residents (convalescent status or discharged) now in community placements; if yes, what are they? Are time limits or other constraints established as conditions for readmission to the institution following community placements; if yes, please specify. Is a formal readmission process required; if yes, is court readmission a required process? Does the institution provide dental, medical, medication/drugs, psychological, educational, social services, and other services to former residents in its community placement or final discharge programming? Do you have a formal procedure for final discharge of community-placed (temporary status) residents; if yes, after what time period are community-placed residents discharged? Does your state have legislation providing for public guardianship of the community-placed resident and/or the institution-placed resident?

The data show that return options are available to ninety-seven per cent (97%) of the residents currently in community placement where they are on convalescent status; if discharged, seventy-four per cent (74%) have this option.

Time limits and other constraints are established for readmission to the residential care facility following community placement in only twenty per cent (20%) of the institutions. Most institutions, fifty-six per cent (56%), require formal readmission procedures; yet only seven per cent (7%) stated that this was a formal court process. The policy of readmission, where necessary when all other alternatives have been exhausted, is encouraging and worthy of support.

Careful involvement and planning should occur between superintendents and community service providers to identify together the issues related to readmission and accountability. This step will tend to reduce unnecessary and defeating problems that arise where such communication planning does not occur.

Respondents were asked to signify whether dental, medical, medication/drugs, psychological, educational, social, and other services were offered to individuals on community placement status or final discharge status. Respondents indicated that nearly all of these services were available to individuals in both categories of placement or discharge status. While all service categories were maintained, regardless of status of the individual, services to those on final discharge status by the institution were minimal.

Eighty per cent (80%) reported having final discharge procedures for community-placed residents. Of those institutions that established time limits, the majority discharged community-placed residents after one year of successful community living. Sixty-nine per cent (69%) indicated there were no time limits established for this activity. The only acceptable criteria for discharge is the best interests of the individual resident in order to insure his rights. Where this occurs, it is a most encouraging trend and should be supported.

Sixty-eight per cent (68%) of the respondents indicate their state has no legislation providing for public guardianship of community-placed residents. Where such policy exists, thirty-nine per cent (39%) indicate it is applicable only to institutionalized retarded individuals. The issue of guardianship, nationally, is overdue for study, review, and new direction in order to assure the legal and human rights of the retarded.

QUESTION 14: Given existing community placement resources, how many placements of residents would you estimate could be made in the next year; and do you feel services these community agencies provide are effective? If no, how could they be improved?

President Nixon has stated that we should: "Enable one-third (1/3) of the more than 200,000 retarded persons in public institutions to return to useful lives." The question we asked was related to the estimate of how many placements of residents could be made in the next year. This question sought differentiation in response by category of disability. The data was positive in several categories; however, only twenty-five per cent (25%) of the respondents checked the statements related to the severe, profound, or infirm population. This points to a lack of confidence by a large percentage of residential personnel that there is indeed appropriate placement facilities for severe, profound, or infirm residents in community settings which can meet the special needs of this population. As cited earlier in the report, these results indicate a need for increased joint efforts of these two groups, institutional and community personnel, to develop facilities, services, and programs for all categorical disabilities and, in particular, for the severe and profound retardates who would benefit from community placement. Sixty-one per cent (61%) indicated that community service agency services are not now effective but could be improved by more training and increased communications with facility staff.

When one reviews the data cited above and the suggestions made in the narrative, it is possible to see that President Nixon's charge can be met. Respondents indicated that seventy-six per cent (76%) of the mild and seventy-four per cent (74%) of the moderately retarded under and/or over eighteen (18)

years of age could be placed in the community if facilities and resources were available. Comparing this estimate, which includes only the mildly and moderately retarded, with the estimate in Table A, relating to the institutional population by categories, the data supports President Nixon's statement that the goal is attainable -- now!

QUESTION 15: How many personnel on your staff are formally assigned to work directly with programs conducted in the community which are not supervised by your institution; how many are full- or part-time, and what is the average of staff man hours per week? In what capacity do your staff personnel work with the community agency? Do you train volunteers from the community to work with community-placed residents?

Eighty-one per cent (81%) of the respondents (range was one to ten) indicated there is one (1) staff person so assigned full-time and one and one-third (1-1/3) persons half-time (range one to thirteen). They average nineteen (19) hours in this activity. Seventy-six per cent (76%) of the respondents indicated they did not train individuals from the community to work with community placement residents. This response indicates insufficient work being performed with home operators, employers, volunteers, and other community agencies.

QUESTION 16: Are nursing homes established specifically for the retarded population existant in your catchment area? If yes, how many and what type?

The majority of the respondents, seventy-six per cent (76%), stated nursing homes have not been specifically established for retarded persons in their catchment area. Of the twenty-four per cent (24%) stating such facilities existed in their catchment area, most reported fewer than ten (10) homes in operation, with an average of two (2) per catchment area. The data shows that nursing homes exist in numbers from one (1) to fifty-three (53). This suggests a wide divergence of definition of nursing home and how the interpretation of federal guidelines of eligibility for nursing homes varies in different states. It should be noted that only one (1) institution reported having fifty-three (53) such facilities in its catchment area. Less than ten per cent (10%) of the respondents indicated that nursing homes specifically established for the retarded were operating in their catchment areas. The majority of the respondents indicated fewer than ten (10) were operant in their areas. Nursing homes are the largest single resource outside of their own homes for the placement of the mentally retarded. Based on this data and the wide divergence and numbers of such facilities, it would be appropriate and wise to study more closely the characteristics of such homes. Placement of mentally retarded individuals in these homes is still a controversial issue, and supportive data is essential to good decisions.

The homes were differentiated by the kinds of care provided. Twenty-seven per cent (27%) of the respondents indicated skilled intensive care nursing homes existed in their catchment areas; thirty-six per cent (36%) of the responding persons indicated there were intermediate nursing care homes; and

fourteen per cent (14%) indicated there were basic care facilities available. Another fourteen per cent (14%) suggested all three types of homes could be found in their catchment areas. This data signals an intense need for greater involvement of institutional personnel and community-based personnel in order to assure the highest quality and quantity of types of treatment and services available to the retarded citizens. Community personnel involved in providing services to the retarded should be encouraged to become involved with institutional personnel in joint endeavors of support and "quality" control of nursing homes caring for the retarded.

QUESTION 17: Please check those characteristics operating in community placement settings located in your catchment area.

TABLE L: Characteristics of Community Placement Settings

| Characteristics | Group Homes | Foster Homes | Nursing Homes | Intensive Care Facilities |
|---|---|---|---|---|
| | (Per Cents of Opinion Responses) | | | |
| Licensure | 79 | 83 | 98 | 97 |
| Written operating procedures | 76 | 72 | 94 | 92 |
| Inspected by regulatory agents | 89 | 89 | 97 | 96 |
| Children: | | | | |
| Severely retarded | 47 | 78 | 65 | 64 |
| Profoundly retarded | 33 | 62 | 65 | 62 |
| Moderately retarded | 73 | 90 | 56 | 57 |
| Mildly retarded | 73 | 92 | 57 | 55 |
| Adults: | | | | |
| Severely retarded | 56 | 54 | 81 | 69 |
| Profoundly retarded | 42 | 36 | 81 | 70 |
| Moderately retarded | 86 | 77 | 81 | 63 |
| Mildly retarded | 89 | 82 | 73 | 61 |

The vast majority reported that State Departments of Public Health, Mental Health, and Social Services are the regulatory agents responsible to inspect and report on these home operations.

This data suggests, in the opinion of superintendents, a major move toward the utilization of group and foster homes. It would appear that the majority of the respondents believe more adults are served by nursing homes and foster homes, and it would seem that at this time group homes are focusing on providing services for mildly and moderately retarded adults, and foster homes are focusing on the same category of children. This data also suggests a need to further develop and emphasize alternatives to institutionalizing severely and profoundly retarded. Fifty-six per cent (56%) of the respondents offered their opinion that records of scheduled fees and charges kept by these facilities are available to the public.

QUESTION 18: Would you prefer that final discharge procedures of community-placed residents be based on performance criteria of the individual in community placement; please specify. What alternative criteria do you use? Are time frames involved in your measurement of attainment of the above?

TABLE M: Final Discharge Procedures

| Time intervals to assess performance criteria: | |
|---|---|
| Six months | 12 |
| Twelve months | 36 |
| Bi-annually | 44 |
| Other | 2 |

Eighty-seven per cent (87%) of the respondents prefer final discharge procedures for community-placed residents and that these be based on performance criteria. They suggest personal performance criteria be assessed at specific time intervals. Most individuals opted for a bi-annual review and, secondly, for an annual review. Performance criteria programs need to be accurately recorded and filed and monitoring procedures conducted in community agencies for former residents now living in those communities. The need for accountability/responsibility in the community and assurance that all needed services are available for such residents are crucial variables in this procedure which will lead to final discharge and full community responsibility.

QUESTION 19: Would you like to have a community-based person who would function at an equal responsibility to you, the superintendent, and to whom you could sign over responsibility for community placement? Who should employ this individual: state, community agency, and if so what community agency?

Respondents were asked their opinions on having community-based persons to function at an equal responsibility level with the superintendent. This concept is supported in the fact that sixty-six per cent (66%) of the respondents expressed a preference for having someone based in the community functioning at an equal level to institutional superintendents. They felt these individuals should be capable and responsible to the degree that they could sign over responsibility for retarded citizens to them. Seventy per cent (70%) felt that this person should be employed by a state level agency, while eighteen per cent (18%) of the respondents suggested this person be employed by community agencies and twelve per cent (12%) indicated either employing source would be acceptable. Other options and choices should be considered in terms of regional agencies, county boards, or other agencies functioning to serve the retarded in given communities.

QUESTION 20: Do residents or placement personnel, before community placement visit community placement, community placement personnel visit the institution? Do the resident and/or parents have selection choice?

TABLE N: Before Community Placement

| Residents or Placement Personnel | Per Cent of Respondents |
|---|---|
| Visit community placement facility | 94 |
| Visit community facility operating personnel | 56 |
| Visit institution | 55 |
| Resident has selection choice | 56 |
| Parents have selection choice | 60 |
| Other | 10 |

This data suggests a need for increased efforts in the area of community placement by facility personnel with community program operators and the reverse of this order (community personnel with facility personnel) in order to lead to reduction of parental objection and to improve resident adjustment to the new location, placement, and life style soon to be experienced. Two very positive trends are noted. These are where residents have selection choice and parents have selection choice options. These trends need to be reinforced; and replication of such efforts for increased, wide-spread practice of this kind of activity should be supported. An interesting and important area for further study would be one of attitudes, particularly satisfaction experienced in the community placement location, wherein parents and retarded citizens had the opportunity to choose during the selection process. These procedures are most important for successful transition processes and should be a part of every community placement program.

QUESTION 21: Which of the following types of programs are carried out with University Affiliated Facilities (UAF) or Centers: research, field experience or practicum assignments, internships, in-service training, diagnostic and evaluation management plans, community placement programs, and other (specify)? Is this an increase over last year?

TABLE O: University Affiliated Facilities/Centers

| Programs | UAF | Non UAF | Both | Neither | % Noting Increase |
|---|---|---|---|---|---|
| Research | 31 | 20 | 8 | 42 | 23 |
| Field experience or practicum assignments | 38 | 21 | 10 | 31 | 33 |
| Internships | 26 | 17 | 4 | 54 | 23 |
| In-service training | 21 | 26 | 12 | 42 | 32 |
| Diagnostic and evaluation | 21 | 24 | 6 | 48 | 18 |
| Management plans | 11 | 24 | 3 | 62 | 19 |
| Community placement programs | 5 | 38 | 1 | 56 | 21 |
| Other | 7 | 4 | -- | 89 | 4 |

This table indicates that university affiliated facilities and/or centers and non-university affiliated facilities are involved in residential care programs. While the per cent noting increase of such involvement is encouraging, it clearly points to a need for greater involvement, particularly on the part of UAF's where residential facilities are located in their catchment areas. This involvement should be purposeful in intent and in action. The question did not ask what kind of programs, other than by topic of such involvement. For example: Who is benefitting from research conducted, the researcher or the retarded individual; what is the cost of such research, field experience, intership, in-service training, and so forth; and who is paying the cost for such experiences? It is interesting to note that only five per cent (5%) of the respondents suggested that UAF's were involved with them in community placement programs. What is more interesting, and indicative of the higher need for more thorough involvement, is the column indicating that respondents suggested neither UAF's or non-UAF's are involved in any of the programs. This data result may be the fault of the question, the way it was worded, or the way it was interpreted and responded to. However, it is significant that these processes and procedures should be examined in intensive detail. One thing is very clear, that is that university personnel, both in UAF's and in non-UAF's, can be and should be important linkage agents for knowledge utilization and dissemination and influence for institutional personnel as well as community-based program operators in meeting the needs of the retarded citizens of this country. Universities are rich resources of accumulated knowledge, expertise, and theoretical procedures to improve the plight of the retarded person, as well as to increase the linkage between institutional personnel and community-based operators in determining joint programs and helping to share the knowledge and practices of both groups and to aid in improved communication processes, as well as interpreting to the larger community the needs and benefits of community placement of retarded individuals.

QUESTION 22: Please describe what you think are essential elements of successful community programs.

Individual respondents nominated the following criteria as those most essential elements for successful community placement. These following criteria were those reported more frequently than others:

1. Pre-placement planning and preparation placement occurs
2. Community support must be present
3. Warm, friendly staff, well-trained in their professions
4. A full array of services, well-coordinated
5. Follow-up activities conducted by state and residential care personnel
6. Adequate programming for community-placed residents
7. Adequate financing for such programs

A number of other criteria were nominated; these, however, represent those most mentioned by respondents.

KEY FINDINGS

1. President Nixon's charge and goal that nearly one-third (1/3) of the more than 200,000 retarded individuals in public institutions be returned to useful lives in the community can be achieved. The data shows that thirty-seven per cent (37%) of the 1972 population in residential facilities were in mild and moderate classifications. The return of individuals in this category to appropriately programmed living facilities would surpass the President's goal -- add the numbers of severe and profound with the potential for placement and possibly one-half (1/2) of all institutionalized retarded could be returned in the same time frame.

2. Residential facility personnel have a high degree of expertise and knowledge -- greater efforts must be made to share information with community-based program operating personnel. The learnings acquired in institutions need to be diffused and utilized for adaptation by such community program personnel working with the retarded.

3. Attention could be given to respite and short-term care programs in residential facilities in order to accomplish several goals. As reported by many institution staffs, the relief that respite care provides for the family often reduces or eliminates the need for long-term institutionalization. Respite care would also encourage a higher degree of interaction between facility and community, permitting greater exchange of knowledge of practice between community personnel and residential facility personnel.

4. Greater attention should be given to the kinds of community programs institutional residents are now participating in, and greater attention should be given to the prioritizing of staff man hours per week assigned to such community programming. Much more work needs to be done with occupational programs and volunteer groups.

5. Again, institutional staffs should look at their time allotments, as it is apparent that insufficient amounts of time are aimed at cooperative training endeavors with other community agencies for operators of community-based homes and programs.

6. Parental participation should be meaningful and purposeful. It should be planned and initiated at the time of admitting their family member to the institution. The focus of institutionalization must continue to move beyond custodial and maintenance care to a process of preparing all individuals to return to their community after receiving the benefit of specialized skills and programs which institutions have to offer. A great deal of attention should be placed on group, foster, and nursing homes for retarded citizens in catchment areas of individual institutional facilities. Definitions and delineations of responsibilities of these entities must be articulated, disseminated, and examined.

7. Increased efforts must be made to develop a system in the community which assigns persons to function on an equal responsibility level as superintendents of institutional facilities. In this way, the assumption of responsibility for mentally retarded citizens by appropriate persons in the community will assure continuity of service and program and assistance for these individuals. This should not be interpreted to mean that citizen advocacy programs should not be encouraged.

8. Community placement procedures should include as many options for residents and parents as possible. Increased articulation of home or community operators and personnel of the institution must be accomplished to insure success of the transition process.

9. Universities across the country should be more meaningfully involved with residential facilities. Programs of intervention should be designed to have a high pay-off for the mentally retarded individual, facility personnel, and community-based operators. Universities have the resources and expertise to accomplish these aims and should be encouraged to assist in this process.

## CONCLUSION

It is clear that much additional research and study need to be done, not only on the above nine (9) key items but on other issues raised in this study. It is clear that the President's charge can be accomplished. This nation has the resources and personnel to perform, in concert, those activities necessary to meet the goal. This interface with residential facility and community agency personnel must take place at a more rapid pace and higher degree of interdependence than in past years.

Time constraints limited the report only to that data believed to be extremely pertinent and which was considered to be most accurate. Many replies were estimates as opposed to actual measurements; much of the data asked for was not reasonably available to respondents. This alone may imply a need for uniformity in record-keeping or in management information systems for residential care facilities.

The findings we have reported are encouraging and signal action and movement in community-facility interaction. They also indicate gaps and/or areas in need of stronger linkages between facility and community personnel.

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David Rosen is President of the National Association of Superintendents of Public Residential Facilities and Superintendent of the Macomb-Oakland Residential Center.

Laurence B. Callan was Program Director of Administration, Institute for the Study of Mental Retardation and Related Disabilities, University of Michigan, at the time of the study and currently is Director of Planning, Evaluation, and Development for the Navajo Health Authority.

All reprint requests to be directed to David Rosen

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